Shankara Chetty's webinar presentation on CovExit.com on August 21, 2021 about the development of his very successful method for outpatient treatment of COVID-19, his experience with the three corona waves in South Africa as well as his experience with people vaccinated against COVID-19. Link to the original: https://covexit.com/the-early-treatment-of-the-delta/ . The lecture by dr. Chetty is part 2.

Start of translation:

Jean-Pierre Kiekens: [00:00:09] Welcome, Dr. Chetty, this is the second time we've seen Dr. have Chetty here. He's had a lot of voice over the past six months or so with his approach because I think he's brought to the forefront so many [00:00:30] aspects of treating the disease that others haven't seen. So this is the place where Dr. Chetty is active. And maybe you can explain who you are beforehand and I'll just leave you alone on the stage. Thank you.

dr Chetty: [00:00:52] Thank you Jean-Pierre. my name is dr Shankara Chetty. I am a general practitioner from South Africa. I [00:01:00] have an interest in science. I studied microbiology, biochemistry and genetics and took an advanced biology course before going to medical school. So my passion is science itself. I run a general practice in Port Edward. It is a resort town surrounded by a number of rural settlements and communities. So I see a wide variety of patients in terms of socioeconomic group, [00:01:30] race and religious groups. So the client base that I have gives me a broad base to examine the differences I've seen with COVID.

Here is an overview. When COVID came to South Africa, there was a distinct misunderstanding about the outbreak of this disease and its course up to hospitalization. There was also a lack of outpatient [00:02:00] early treatment options. Doctors were encouraged not to treat patients, not to see patients. Patients were discouraged from seeing a doctor. Public health measures seemed to consist only of isolating unwell patients until they were so ill that they had to be taken straight to hospitals.

When the first COVID cases began to appear in South Africa, I took the initiative by isolating myself from my family and keeping my [00:02:30] practice open to physically see each patient and see the progression of the disease from onset to the point at which patients might need to be

hospitalized. Very early on in examining these patients, my interest focused on the occurrence of dyspnea, which appeared to be the symptom that heralded hospital admission, and so I encouraged [00:03:00] any patient to self-assess if their symptoms worsened report so I could understand what was going on.

I have found that the initial illness is a typical viral diseasewas. It had some quirks, like loss of smell and taste, but overall it was a simple respiratory disease. It seemed to start with the sore throat, which got worse over time. But [00:03:30] the majority of patients showed signs of improvement as early as the fifth or sixth day of illness. Her appetite returned. The fever had subsided. One had the feeling that they were on the mend. Of course, there were also patients who only had a sore throat for a day and recovered within a day or two. In the initial phase, there were a large number of clinical pictures. But as with any flu, some people are more severe than others.

Now I asked the patients to come back if they noticed shortness of breath or a worsening of symptoms, and the patients who came back with a worsening of symptoms , unusually , always presented on the eighth day, exactly one week after the onset of their symptoms , to come back So I started questioning that by tracing back the onset of symptoms, and I found that for every patient it was day 8 that the onset of shortness of breath. [00:04:30]

So at the beginning of the disease, steroids were the drug of choice. We know this is a steroid responsive disease and that was the starting point for starting my steroid treatment with the patients. I treated the first seven days of the illness like a normal flu.I added doxycycline to my early protocol simply because of doxycycline's ability to suppress viral replication. [00:05:00] It has an anti-inflammatory effect. It inhibits protein synthesis. All of these properties make it an ideal candidate for an early treatment that stops the virus from dividing too quickly. I have also treated patients and other family members who were not infected with doxycycline prophylactically. And I found that it had some benefits. So that was one of the mainstays of my treatment, even during this third wave. The rest was generally symptomatic treatment. I added aspirin [00:05:30] to my early protocol because we were aware of clotting and things

On the eighth day, the patients experiencing shortness of breath were quickly switched to a steroid. It took three or four days for these early patients to

improve and recover. But the onset of symptoms on day eight seemed too obvious to ignore. At that point I [00:06:00] began to look into the various pathologies and what would trigger this disease that seemed to start on the eighth day. And, of course, there was a very large proportion of patients, about 70 percent, who did not deteriorate by day eight and fully recovered from the initial illness.

So I thought we were dealing with a biphasic disease . There was no linearity. There were patients [00:06:30] who recovered very quickly for the first few days of the illness, spent the rest of the week perfectly well, and then got sick again on the eighth day. Some of them became seriously ill within a very short time. So on that eighth day I began to differentiate and classify the disease according to the severity of the symptoms. The first seven days did not seem to affect the severity of the disease, which followed from day eight [00:07:00].. So I found mild cases where they responded by day 8 but subsided very quickly over a day with no sequelae. In other patients, the reactions were moderate. And of course, these reactions would last for months if not treated appropriately. That was classified as Long COVID, a moderate illness, and the severe cases had reactions that progressed rapidly and, if left untreated, would end [00:07:30] in intensive care within a day or two.

From the classification of this disease, I realized that I was dealing with something unrelated to the virus itself . It was arguably more of a response to the virus, an individual response to the virus, that produced these varying degrees of disease severity. The only illness or type of pathology that seemed to fit this pattern by day eight was a reaction to an allergen.Some [00:08:00] react strongly to an allergen, others more mildly. Some would not react to an allergen at all unless they are allergic. So I looked into this and thought a try of an antihistamine on day 8 might be beneficial and speed of recovery is key when using medication. The speed of recovery, if fast, would indicate a mechanism.

After [00:08:30] about four or five patients recovered from the steroids, I gave the next patient who came to me the steroid, but also a dose of promethazine. I chose the first-generation antihistamines because they have a broad spectrum of action. And of course, it's stronger antihistamines to curb any reaction. Amazingly, the first patient I gave an antihistamine to had her hypoxia gone

within a day . The next [00:09:00] day when we contacted her her hypoxia had resolved and she was feeling better and recovery was much faster than those on steroids alone.This lends credibility to the hypothesis that it is some kind of hypersensitivity trigger for this reaction. So, from that day on, the promethazine became part of my treatment, and thinking hypersensitivity, I added montelukast. I have used [00:09:30] montelukast extensively in the past to treat and prevent anaphylactoid reactions in patients where we could not identify the offending allergen. And it has worked relatively well as a preventive measure. So on day 8 montelukast was started. For those patients who could afford it, I started earlier, hoping to quell the reaction. However, this did not prove particularly beneficial in subverting the reaction on day 8, but had utility once [00:10:00] the 8th day.

So the eight-day treatment protocol consisted of a dose of steroids, antihistamines, montelukast, and of course an anticoagulant , depending on the patient's D-dimer levels and predisposition. Anticoagulants ranged from aspirin to aspirin and clopidogrel to Xarelto rivaroxaban at a dose of 15mg twice daily when the D-dimer was rising. I've found in all of my patients [00:10:30] that whatever the level of D-dimer, it started to stabilize within three or four days. In the first and second waves, I took the opportunity to examine the different biomarkers and see how they change as the disease progresses.

I found that levels of CRP and levels of interleukin, that is, interleukin-6, were critical in delineating disease progression. For the first seven days, interleukins and CRP are elevated, but only minimally [00:11:00], as seen in the average flu. From the eighth day, however, these would increase exponentially. The increase in these values was a good marker to show the effectiveness of the treatment. I've seen interleukin levels in the 500 range, interleukin 6 and CRP in the eight and nine hundred ranges. But I managed to get rid of them within three or four days with the help of the treatment method. So all patients [00:11:30] were started on this type of treatment.

Of all the treatments I have used to date, the antihistamine promethazine seemed to have the most effectiveness compared to all other drugs in reducing hypoxia in a timely manner. The steroid dose also had to be increased very quickly in order for us to achieve a quick reversal in these markers. The

steroid dose initially raised [00:12:00] a lot of eyebrows in the medical community. However, the correct dosage of the steroids is crucial in containing the reaction and suppressing further consequences. The lower the dose of steroids that you use inappropriately to reverse this response, the longer you will need to use a steroid and expose the patient to a steroid.

It became clear to me relatively quickly that I was no longer treating viral pneumonia . There were [00:12:30] patients with viral pneumonia, but they were few. And given the lack of effectiveness of the antivirals in getting patients into the hospital, I was under the impression that the patients that were hospitalized didn't have any real viral problems. We were dealing with hypersensitivity pneumonitis rather than viral pneumonia, and the high-resolution CT and X-ray could not distinguish the two. So I think it's just a simple misdiagnosis with all the hype surrounding the virus [00:13:00] itself. TheSo the procedure worked relatively well. It could be adapted for rural settings and intensive care units . We have used intramuscular antihistamines and intravenous steroids and have found that these methods can speed recovery.

In the second wave, it became somewhat clear that the culprit for this reaction was the spike protein. The mutation that [00:13:30] gave rise to the infamous South African variant only caused a change in the virus's spike protein, nothing else. And that mutation made the variant much more contagious, and it had an affinity for the ACE2 receptors in the gut. So, in the second wave, there were many more gastrointestinal symptoms, and by day eight, a far more severe hypersensitivity reaction was elicited that required a far higher dose of steroids for suppression compared to the first [00:14:00] wave.

So it was obvious that the spike protein was the cause of this hypersensitivity , as it was the only one that had changed. The third wave is the infamous Delta variant. With the Delta variant, we observed the same pattern in unvaccinated patients. In South Africa, the introduction of the vaccine has only recently started. So the first and second waves were the [00:14:30] treatment of unvaccinated patients, and they followed the usual evolution of the disease itself. In this third wave, where we see unvaccinated patients, the trajectory is in usually similar. About 30 to 40 percent of patients experience a relapse on the eighth day. However, the symptoms have changed.

The first wave was more respiratory. The second wave, with the South African variant, was more gastrointestinal, and [00:15:00] now, with the Delta variant, it's respiratory symptoms again. I experience a lot more sinusitis. I see more and more middle ear infections. So upper respiratory infections, sore throats. Very few patients develop the persistent cough that we observed in the first and second waves. However, there are also those in whom the initial symptoms of the disease have progressed a little. Strangely, loss of smell and taste is not that common, but I've had [00:15:30] a few patients who lost their smell and taste by day eight.

They had the smell and taste during the initial viral phase and suddenly lost their smell and taste on day 8. So I used that as a symptom of the beginning of the second phase of this disease. We apply the same treatment method to the Delta variant itself. In the early viral phase, the first wave, I've had good experiences with both hydroxychloroquine and ivermectin [00:16:00] to lower viral loads in critically ill patients. Unfortunately, until now we have not had wide access to these drugs to use them in almost all patients. However, I use it cautiously in patients who I suspect have high viral loads, high fevers, physical aches and pains, all those things. And it seemed to curb the worsening of symptoms. Within two or three days the patients were somewhat recovered and the pain subsided. [00:16:30] And so I took that as a measure of effectiveness that I was able to suppress viral loads with these drugs. However, in the second wave, hydroxychloroquine showed no benefit at all during those first few days. However, ivermectin worked and I used a lot of ivermectin in the second wave. Now, in the third wave, I'm noticing a change again. Those patients who have a high viral load in the first phase of this disease appear to respond to hydroxychloroquine. 200 Plasmoquin is what we use 200 mg [00:17:00] twice a day for five days. It seems to curb the viral spread. Within two or three days the patients were somewhat recovered and the pain subsided. [00:16:30] And so I took that as a measure of effectiveness that I was able to suppress viral loads with these drugs. However, in the second wave, hydroxychloroquine showed no benefit at all during those first few days. However, ivermectin worked and I used a lot of ivermectin in the second wave. Now, in the third wave, I'm noticing a change again. Those patients who have a high viral load in the first phase of this disease appear to respond to hydroxychloroquine. 200 Plasmoquin is what we use 200 mg

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In the second part of the disease with the delta variant, we see pretty much the same thing: the patients' oxygen saturation decreases. In both the second and third waves, the decline in oxygen saturation seems to be delayed a bit. And if we wait for this delayed fall in oxygen concentration, we will miss the boat. Therefore, we have started to educate patients about other symptoms that usually appear on this eighth day so that patients can seek treatment in a timely manner. The most common [00:17:30] symptom I see with the Delta variant is fatigue. So, on the eighth day, patients suddenly feel this overwhelming fatigue, and that's a dangerous sign. Therefore, I instructed the patients

I have also noticed that in this third wave with the delta variant, the coagulopathy is much more common. In the first and second waves and in the third wave I have found that if the hypersensitivity is contained very [00:18:00] early and aggressively it makes any further treatment unnecessary because then we are neither in the hyperinflammatory phase of the disease still in hypercoagulability. However, in patients who come a little later or who are not treated appropriately or aggressively enough, on day 11 we find that the inflammatory markers are greatly increased and the patient has severe inflammation. Steroids are then extremely important. D-dimers appear to increase from day 13 to 14, even [00:18:30] in patients where you have the other markers under control. Therefore, it has become crucial for patients on anticoagulants in this delta variant that we are going through

And now the vaccinated patients have presented quite a lot of what we're seeing. Very early on it became clear that vaccinated patients presented with unusual symptoms, particularly those who had been vaccinated with mRNA vaccines. In South Africa we have two vaccines [00:19:00], the mRNA which is being given to more private patients and the Johnson & Johnson vaccine which has been issued to all government employees, teachers etc. With the

Johnson & Johnson vaccine, I noticed very quick side effects. The patients complained of headaches and all the usual side effects that we know. And that was usually a day after vaccination. With proper treatment, these seemed to go away. I have not noticed any other serious side effects with the adeno vector based vaccines either. [00:19:30]However, with the RNA vaccines, with the Pfizer vaccine being used here in South Africa, I have found that a large proportion of patients develop COVID seven to 10 days after vaccination. Therefore, it is very important to note the vaccination status of each patient and also to document the time span between the onset of the disease and the vaccination itself. It's pretty obvious that the patients got or thought to get COVID seven to ten days [00:20:00] after vaccination and had all the relevant symptoms: body aches, sore throat, a little fever and the rest.

But oddly, some of these patients collapsed within three or four days of their illness.They became hypoxic and had to be hospitalized very, very early. This has never been observed in first and second wave natural infections in unvaccinated [00:20:30] patients. That seemed strange to me. I think the 7-10 day COVID illness that we see in vaccinated patients, or 7-10 days after vaccination, is probably spike protein disease. The spike protein on day eight of a natural infection tends to trigger this allergic reaction, and if left unchecked, it spirals out of control very quickly, leading to a cytokine storm, clotting problems, and everything else. So I felt that those patients who [00:21:00] felt unwell on the seventh day were on the natural infection scale by the eighth day of illness and that their blood oxygen levels would drop relatively quickly. So a patient whose blood oxygen level dropped on the fourth day is actually a patient who is sick on the 12th day, because the first day was actually the 8th day that we had overcome the viral phase of the disease in vaccinated patients.

So I started treating these patients with the same meds that I'm using on day eight [00:21:30] with antihistamines, montelukast and a dose of steroids to calm the situation. Anticoagulation is crucial, and I started measuring the markers early on. I didn't wait until day 8 to start examining the markers to decide on treatment options and I've seen some benefits from doing so.

So we need to know the vaccination status of the patients and how long it has been since they were vaccinated in order to assess how effectively we will

intervene. Those patients who had been vaccinated [00:22:00] more than a month earlier and contracted COVID were likely true breakthrough infections. And the majority of these patients showed the typical appearance of a natural disease in unvaccinated patients. They had the viral phase of the disease. They had the fall in oxygen saturation on the eighth day. They were all made aware of this and returned for treatment on the eighth day and we managed to reduce a large proportion of the mortality and morbidity.However, we saw something [00:22:30] unusual in vaccinated patients who developed COVID one month after vaccination. Some of them looked absolutely fine on the eighth day. And so also on the ninth and tenth. And as soon as you took your eyes off the patient, the oxygen saturation began to fall, and it seemed as if the fall in oxygen saturation of the blood had been postponed to a later date. That seemed strange to me. This happened in a few patients, but in those who started to drop in blood oxygen saturation, it dropped very, very much [00:23:00]. They seemed to be the most severe COVID cases, which I had ranked by severity from the eighth day. I looked at this and found it very strange.

So I consulted with some of my colleagues in India who had observed the same thing: For vaccinated patients who developed COVID [at least] a month after vaccination, the onset of the fall in oxygen saturation was much later than day 8 [after onset of symptoms]. I suspect [00:23:30] that the vaccine can induce some level of tolerance to the spike protein. So when patients are exposed to free spikes of infection on day eight, they don't really respond because they have some tolerance. However, once this tolerance is overcome, they respond over the course of a few days. And when they react, those prone to strong reactions will react very violently. That's why I think it's important that we triage the patients and [00:24:00] find out about their vaccination status and know how long it's been since the last vaccination. This could be explained in part by antibody-dependent enhancement.

We've seen this in the animal models testing these vaccines and it's something to be very careful about in the future. There has been a lot of success with the treatment and I hope it becomes more widespread. I hope we can use ivermectin a little more in [00:24:30] South Africa and learn a lot more about how to use it in the three stages of this disease. So I hope that Dr. Kory can

give me a lot of insight into this topic and I can use it to shake a few cages. That's why I think it's important that we triage the patients and [00:24:00] find out about their vaccination status and know how long it's been since the last vaccination. This could be explained in part by antibody-dependent enhancement. We've seen this in the animal models testing these vaccines and it's something to be very careful about in the future. There has been a lot of success with the treatment and I hope it becomes more widespread. I hope we can use ivermectin a little more in [00:24:30] South Africa and learn a lot more about how to use it in the three stages of this disease. So I hope that Dr. Kory can give me a lot of insight into this topic and I can use it to shake a few cages.

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Jean-Pierre Kiekens: [00:24:42] Thank you very much. Thank you. dr Chetty, yes we have this time constraint but at the same time you have this wealth of expertise and I think it's so important to have these perspectives from around the world. I just want to share a slide.

It's not from South Africa, but I want people [00:25:00] to imagine that. This is the early treatment kit. This has been used in many countries since April, May last year. This is the key. It is a home treatment kit. There are many, many types of kits. It is for illustrative purposes only. You need this for early outpatient treatment. The government and health authorities should [00:25:30] provide a home treatment kit. You shouldn't tell people to go home without some form of treatment. Refusal of treatment is the leading cause of hospitalization. I hope you know that's what I want. This is outrageous. In my opinion, the issue is still relevant and there are countries who understood it

very well. For example Salvador and there are others who don't want to understand it. Hopefully it will be available everywhere [00:26:00] in the world because like you said Dr. Chetty, both vaccinated and unvaccinated people are susceptible to this disease, including severe illness.

end of translation

Overview of all 7 parts of this series with links:

dr Chetty's Covid Treatment Part 1 Translation of Dr. Chetty's discovery and method for treating Covid in Modern Medicine, August-September 2020.

dr Chetty's Covid Treatment Part 2 Translation of a webinar lecture by Dr. Chetty, Aug. 21, 2021 at Covexit.com

dr Chetty 's Covid Treatment Part 3 Chetty in Modern Medicine, August-September 2020. Dr. Chetty described his observations and his method after 200 successful Covid treatments at the time.

dr Chetty's Covid Treatment Part 4 Interview by Dr. Mobeen Sayed with Dr. Chetty, probably early Nov. 2021

dr Chetty's Covid Treatment Part 5 Link to the highly recommended Corona Committee simultaneous translation interview on 10 Dec 2021, with Dr. chetty

dr Chetty's Covid Treatment Part 6 Interview by Dr. Philip McMillan with Dr. Shankara Chetty on Dec 4, 2021

dr Chetty's Covid Treatment Part 7 Translation of an interview by Jean-Pierre Kiekens with Dr. Chetty, 22 Dec 2021 at Covexit.com

Translation of the abstract by Dr. Chetty's Phase 2 Treatment Protocol . As a pdf file. For the information of doctors only.